Debbie Miller Dermatology Health History and Review of Systems

Date:_____

Patient Name:_____ **DOB:**_____

Nickname:_____ **Occupation:**_____

Primary Care Provider & Their Clinic Name:_____

Are you allergic to: **Dental Anesthesia** **Yes** or **No** **Band Aid Adhesive** **Yes** or **No** **Latex** **Yes** or **No**

Do you have any of the following *(Check conditions that apply)*

Melanoma_____what year_____ **Basal Cell Carcinoma**_____what year_____ **Squamous Cell Carcinoma**_____what year_____

Cancer (*other than skin listed above*)Type & Year_____ **Artificial Joint**_____ **Artificial Heart Valve**_____

Asthma____ Blood Clots____ Diabetes____ Emphysema____ Heart Attack____ Hepatitis____ HIV/AIDS____ High Blood Pressure____

Kidney Problems____ Lupus____ Multiple Sclerosis____ Thyroid____ Rheumatologic____ Stroke____ **Fear of Needles**?_____

Are you currently experiencing : Shortness of Breath__Chest Pain__Nausea/Vomiting__Weakness/Numbness__Headache__Fever/Chills__

Do you have a Pacemaker/Defibrillator? **Yes** or **NO** **Who is your Cardiologist?**

Vaccinations: Did you get your Flu Shot this year? **Yes** or **No** Have you received a Pneumonia Shot? **Yes** or **No** (Year)_____

Family History

Are you Adopted? **Yes** or **No** *(If you don't know your family history please write N/A in space below)*

	Alive	Deceased	History of Cancers	History of Melanoma/Carcinoma	Misc. Medical Conditon
Mother					
Father					
Siblings					
Children					

Women are you: Pregnant: **Yes** or **No** Trying to Get Pregnant: **Yes** or **No** Breastfeeding: **Yes** or **No**

Do you *or* ***have you had any of the following sun exposures:***

1. Enjoy Outdoor Activities? **Yes** or **No** **2.** Experienced **Blistering Sunburns**? **Yes** or **No** **3. Wear Hats?** **Yes** or **No**

4. Wear Sunscreen? **Yes** or **No** **5.** Use Tanning Beds? **Yes** or **No** **6.** Work or Worked Outdoors? **Yes** or **No**

Tobacco Use: **Never Smoked**___ (*If you've Never smoked please go to next section*)

Current Smoker___ (*If Current please answer/circle* ***ALL Questions*** *below*)

1. How often do you smoke? **A**) Every day **B**) Some days

2. Are you interested in quitting? **A**) Yes **B**) No **C**) Ready to quit

3. Once awake how soon do you smoke? **A**) 5 minutes **B**) 6-30 minutes **C**) 31-60 minutes **D**) 1 hour or more

4. How many cigarettes a day do you smoke? **A**) Up to 5 **B**) 6-10 **C**) 11-20 **D**) 21-30 **E**) 31 or more

5. What age did you start smoking?_____

Former Smoker___ (if you smoked in the past please answer/circle **ALL Questions** below)

1. When did you quit? **A**) less than 1 month **B**) 1-3 months **C**) 3-6 months **D**) 6-12 months **E**) 1-5 yrs **F**) 5-10 yrs **G**) 10 or more yrs

2. What age did you **START** smoking?_____ **3.** What age did you STOP smoking?_____

List ALL Medications (*Both* ***Prescriptions*** *and* ***Over the Counter***)_____

_____

_____

_____

Drug/Medication Allergies:

By signing this form I agree to allow Debbie Miller Dermatology and its providers to share my information with my primary care providers, insurance companies, pharmacies, or other facilities which are deemed necessary for my medical Care. I also understand if I refuse to sign this document I may have to pay for my visits out of pocket, may not receive my prescriptions and may be unable to continue my medical treatments as recommended by Debbie Miller Dermatology and its providers. I also confirm that all of my contact information and insurance information is correct and valid as of the date of my signature below.

Patient Signature:_____

Staff Signature:_____